STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	1300 East Tremont Street Hillsboro, IL 62049

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident's emergency contact after an injury was sustained for 1 (R5) of 3 residents reviewed for notification. Findings include: R5's Undated Face Sheet, documents V29 is her emergency contact. R5's Quarterly Minimum Data Set (MDS), dated [DATE], documents R5 is alert. R5's Health Status Note, dated 10/21/2025 at 10:50 AM, documents PT (Physical Therapy) staff informed RN (Registered Nurse) that patients left anterior lower extremity was swollen and bruised. NP was in house and was notified to take a look, patient had a silver dollar sized bruise on the anterior shin/ankle, with redness and edema spreading around the bruise. Patient stated that she has broken that same leg/foot 3x and there is some hardware in there from past surgeries. Patient said when they were transferring/pivoting her feet gave out. NP assessed patient quickly and RN was given the order to send patient to the ER (Emergency Room) for imaging evaluation. Patient was sent to the ER at approx (approximately) 8:45am via EMS (Emergency Medical Services).On 10/31/2025 at 1:25 PM, V29, R5's emergency contact, stated no facility staff notified her on the morning of 10/21/2025 when R5 sustained an injury and was transferred to the emergency room. V29 stated R5 called her and told her she got her left foot stuck in the wheelchair wheel and her left foot/lower leg was injured and she was sitting in the emergency room. V29 stated she was upset because no facility staff notified her R5 was injured or that she was transferred to the emergency room, and if she would have been notified of the severity of the injury she would have met R5 at the emergency room to be there for family support. The Facility's Significant Condition Change and Notification policy, dated 12/2024, documents purpose: to ensure that the resident's family and/or representative. A significant change in resident's physical status includes onset of swelling, skin discoloration and transfer of the resident from the facility. Procedure: when any of the above situations exists, the licensed nurse will contact the resident's representative. Calls will be made to the resident's representative until they are reached. A message may be left on an answering machine that does not give specifics but leaves a request for the facility to be called.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent abuse from occurring and failed to document progressive interventions for 3 of 3 residents (R3, R7, R9) reviewed for abuse in the sample of 10. These failures resulted in R3 having R4's hands around her neck aggressively, R7 being hit in head by R4 and also being pushed down in chest by R4 while in bed, and R9 being slapped by R4. Using a reasonable person concept, R3, R7, and R9 would experience discomfort/pain and feelings of being scared, unsafe, shame, and humiliation. Findings include: R4's face sheet documents an admission date of 1/6/2025. Diagnoses include Vascular Dementia, Peripheral Vascular Disease, Chronic Atrial Fibrillation, and Cerebral Infarction. R4's Minimum Data Set (MDS), dated [DATE], documents R4 is severely cognitively impaired. R4 is independent with walking. R4's care plan, updated 8/6/2025, documents R4 has the potential to be aggressive related to dementia diagnosis. Interventions include approach/speak in a calm manner, divert attention, remove from situation ant take to alternative location as needed. Intervene as necessary to protect the rights and safety of others. Medication review will be done when appropriate, by psych Nurse Practitioner, NP. Transfer to inpatient psychiatric facility. R4 lives on a closely supervised unit. R4 on 1:1 observation. R4 will be redirected by offering activities or snack when agitation is noted. R4's care plan does not document abuse. R4's care plan does not include documentation of progressive interventions for incidents that occurred on 10/7/2025, 10/18/2025, 10/21/2025. 1.R3's face sheet documents admission date of 7/16/2024. Diagnosis include Alzheimer's Disease, Cerebrovascular Disease, Cerebrovascular Infarction, Heart Failure, Aphasia. R3's MDS, dated [DATE], documents R3 is severely cognitively impaired. R3's MDS dated [DATE] documents R3 requires moderate assist with walking.R3's care plan, updated 10/23/2025, documents R3 has been identified as being a vulnerable person related to her diagnosis of dementia. Interventions include frequent rounding by staff is provided to maintain safety and ensure resident needs are met. R3 resides on a closely supervised unit.Facility initial report, dated 10/14/2025, documents on 10/7/2025, it was reported R4 put her hands on R3's neck. The residents were immediately separated by staff and were placed on 1:1 monitoring. All parties were notified. An investigation initiated. Head to toe assessment completed with no injury to either resident. Neither resident can make a statement as to what happened. Staff were interviewed. Following the investigation into the incident, the staff responded appropriately to the incident. Staff placed R4 on 1:1 observation and sent to local hospital.On 10/30/2025 at 10:00AM, V19, CNA/Certified Nursing Assistant, stated, I was working on 10/7/2025 when R4 had an altercation with R3. I was walking with R4 back to her room for bed. When R4 and I walked into the room R4 looked at her roommate (R3), who was lying in bed, and said, 'Is that my grandmother?' I said, 'No that is not your grandmother'. R4 suddenly walked over to R3's bed, put her hands around R3's neck and began choking her. I immediately leaned across R3's body while at the same time taking R4's hands off R3's neck. When I got R4's hands released I took R4 out to the nurse working the hall and R4 was sent out to the hospital. I know R4 was on 1:1 observation for a while. I don't know for how long. No one was injured.2.R7's face sheet documents an admission date of 7/21/2025. Diagnoses include Dementia, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Atrial Fibrillation. R7's MDS, dated [DATE], documents R7 is severely cognitively impaired. R7's care plan indicates R7 has been identified as a vulnerable person. Interventions include R7 lives on a closely supervised unit.Facility's initial report, dated 10/18/2025, documents on 10/18/2025 at 5:45PM, R4 smacked R7 on the top of the head. Residents immediately separated. R4 was placed on a 1:1 observation for monitoring until R4 was sent to local hospital. Licensed nursing staff conducted a head-to-toe assessment with no injury noted. Investigation initiated. Neither resident able to make a statement regarding incident. On 10/30/2025 at 11:00AM, V21, Licensed Practical Nurse/LPN, stated, The incident on 10/18/2025 was between (R4) and (R7). We were in the dining room and (R4) had gotten up to leave. As (R4) was exiting the dining room she looked at (R7), who was sitting in her wheelchair. (R4) walked over and tap, tap, tapped (R7) on the head. (R7) turned around and grabbed (R4's) hands. They had their hands locked. I ran over and unlocked their hands and separated them. I called (V1, Administrator) and had (R4) sent out to the hospital. She came back a couple hours later and was put on 1:1 observation. When I work back there, I try to keep the medication cart in the center of the hallway so I can keep an eye on both ends of the hallway.Facility's initial investigation, dated 10/21/2025, documents on 10/21/2025 at approximately 1:30AM, it was reported to the administrator that R4 acted in an inappropriate

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to transfer 1 (R5) of 3 residents properly and failed to update a resident's care plan (R10) with progressive interventions to prevent future falls for 2 residents reviewed for accidents and falls in the sample of 3. These failures resulted in R5 having swelling and bruising to left ankle/lower leg and being diagnosed with an acute on chronic distal tibial fracture. Findings include: 1. R5's Care Plan documents at risk for falls r/t (related to deconditioning. Goals: the resident will be free from falls and injury through the review date. Intervention included utilize 2 assist for transfers dated 9/28/2025. R5's Quarterly Minimum Data Set (MDS), dated [DATE], documents R5 is alert. R5's Physician's Order Sheet (POS), dated 10/1/2025, documents resident requires assist of 2 for all transfers due to knee giving out without notice. R5's Health Status Note, dated 10/21/2025 at 8:13 AM, documents, Sending patient out to local ER (Emergency Room) after staff attempted to get resident up this morning and her Lt (left) ankle became twisted and caught up during transfer. lateral Lt ankle has an area of localized bruising and swelling along with a noted discoloration going up her leg above the ankle. she has a history of multiple fractures and hardware to her Lt ankle. needing stat imaging and evaluation.R5's Health Status Note, dated 10/21/2025 at 10:50 AM, documents, PT (Physical Therapy) staff informed RN (Registered Nurse) that patients left anterior lower extremity was swollen and bruised. NP (Nurse Practitioner) was in house and was notified to take a look, patient had a silver dollar sized bruise on the anterior shin/ankle, with redness and edema spreading around the bruise. Patient stated that she has broken that same leg/foot 3x and there is some hardware in there from past surgeries. Patient said when they were transferring/pivoting her feet gave out. NP assessed patient quickly and RN was given the order to sent patient to the ER for imaging evaluation. Patient was sent to the ER at approx 8:45am via EMS (Emergency Medical Services).R5's Health Status Note, dated 10/21/2025 at 10:54 AM, documents, the resident is experiencing a change in condition. See SBAR assessment for further information and family/physician The change in condition the resident is currently experiencing is Bruise and edema on left anterior ankle. NP gave orders to send patient to the ER.R5's Health Status Note, dated 10/21/2025 at 11:39 AM, documents, This RN spoke with (RN) at the ED at (local) area hospital regarding patient. A 2 view Xray of tib/fib (tibia/fibula) came back with findings of Medial tibial plateau fracture is present. There is intramedullary rod in the distal fib and tib, and indeterminate obliquely oriented fracture involving the distal tibial shaft. Patient is coming back splinted and 4mg of morphine was given at 8:45am from EMS. Patient has an appointment with Dr. [NAME] 8:45am. Administrator, ADON, Transport all made aware.R5's SBAR Communication Form and Progress Note, dated 10/21/2025, documents, situation: bruise and edema on left anterior ankle which started on 10/21/2025, symptoms worse when moving it and nothing makes it better. Other relevant information: patient was transferring/pivoting and legs gave out. Functional Status Changes: weakness. Nursing Note: NP gave orders to send patient to the ER (Emergency room.)R5's Emergency Medical Services (EMS) Run Sheet, dated 10/21/2025, documents they were called to the facility due to R5 fell and had an injury to her ankle. Left leg pain, swelling and tenderness documented and EMS staff administered 4 milligrams (mg) Morphine intravenous for pain. R5's ED (Emergency Department) Paperwork, dated 10/21/2025, documents, chief complaint: fall. History of Present Illness Narrative: patient presents after sustaining an injury yesterday in which her leg became caught in a wheelchair, resulting in pain and a fall. She reports pain localized to the distal third of the right (should be left) leg with associated swelling and bruising. X Ray imaging reveals an indeterminate fracture involving distal tibial shaft, raising concern for an acute fracture following the recent trauma. ED course: this patient sustained a traumatic injury resulting in pain, swelling and bruising localized to the distal third of the right (should be left) leg. This injury requires evaluation by orthopedics and may involve multiple management options depending on the final diagnosis and recommendations. The presence of swelling and bruising, along with the need for a specialist consultation, increases the complexity of the problem addressed beyond a simple, uncomplicated injury.R5's Health Status Note, dated 10/22/2025 at 7:38 AM, documents, Resident was sent to hospital to be eval. Resident has an appointment with ortho (orthopedics). Resident is a (mechanical lift) for all transfers at this time.On 10/29/2025 at 10:45 AM, V7, CNA (Certified Nurse Aide), and V8, CNA, entered R5's room to transfer her from recliner to bed. V7 and V8 used a mechanical lift to transfer R5 at that time. On 10/29/2025 at 11:50 AM, R5 sat in her recliner in her room. R5 was alert and stated when she injured her left foot, it was